

The future of child protection

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INTRODUCTION

The abuse of children is as old as mankind, but delineation of child abuse as a recognizable clinical entity dates back only to 1962 when a classic paper by Kempe *et al.* described the key features of physical abuse.¹ Since that time, the spectrum of child abuse has grown to include sexual abuse, emotional abuse and neglect. Gradually, various more subtle manifestations of abuse were identified, including the puzzling and often bizarre clinical syndromes known originally as Munchausen syndrome by proxy (MSBP) and now categorized as fabricated and induced illness (FII). Taking a more global perspective, child trafficking and prostitution, forced child labour, and the abduction of children to be trained as soldiers can all be regarded as forms of child abuse, but these are beyond the scope of this review.

In the last few years, a series of high profile controversial child protection cases has shaken the confidence of paediatricians. A recent survey showed that most specialist registrars would seek a consultant job in which they would not have to be involved in this work. This is most unfortunate: first, because it puts an excessive burden on the few doctors willing to take on such cases; and secondly, because doctors who are reluctant to consider the possibility that a child's symptoms could be related to ill treatment may make clinical errors and miss opportunities for effective intervention.

COMMON FEATURES OF CHILD ABUSE

The features of physical abuse are now well known. The manifestations include bruising, cigarette burns, fractures, intra-cranial haemorrhage and intra-abdominal injuries. Typically the child presents hours or days later than might reasonably be expected, given the nature of the injuries, and the history is incompatible with the findings. In some cases, the child has previously been well cared for and the abuse may represent a sudden loss of control by an exhausted, stressed parent. In others, there is evidence of long standing abuse, with injuries of varying ages and, in many cases, signs of under-nutrition, poor hygiene, emotional abuse and

neglect.² Domestic violence between adult partners is often associated with child abuse.

Sexual abuse may accompany physical abuse but often the features are more subtle. Although the public image of the perpetrator is focused on the 'stranger in the park', in reality the majority of those who sexually abuse children are respectable adults who are members of, or known to, the family. The abuse often develops over a long period of time, starting with inappropriate touching or other actions and only coming to attention much later as the child gets older and more willing to disclose what has happened.

THE CHANGING CONTEXT OF CHILD ABUSE

For paediatricians, child abuse has always been a painful subject—one senior paediatrician sadly observed that coming to terms with the fact that parents could sometimes harm their children had been the hardest thing in his career. In the early days of child protection work, the cases were often very distressing but usually not very difficult, because the presentation and findings were all too easy to interpret.

It was then recognized that many of the children who died at the hands of their parents had suffered repeated but less lethal episodes of abuse before the fatal event. Thus, it became clear that clinicians should be more willing to consider abuse as part of their differential diagnosis for any unexplained injury or obscure physical findings, so that intervention could be arranged before it was too late. The price of missing the diagnosis or ignoring warning signs can be a dead or brain injured child, or years of avoidable misery. Inevitably, as the threshold for suspicion changed, the risk of being wrong increased. But whereas in other areas of clinical practice, the price of such errors is usually an investigation with a negative result, in child protection the outcome can be a distressed angry parent or the unjustified removal of a child from his family.

The role of doctors in child protection has been clearly defined in Government guidance. The duty of the doctor is to:

- consider the possibility of child abuse
- review the history and physical findings
- form a clinical judgment, obtaining further expert opinions where appropriate.

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Sometimes, in spite of the best available medical expertise, uncertainty will remain as to whether or not a child has been abused. The doctor's job is to identify cases where child abuse *may* have occurred. They may sometimes have to make clear their suspicions to parents, but they do not have to decide whether a crime has been committed, or by whom—that responsibility rests with the police. The lead agency for child protection is social services. It is their duty to convene a child protection conference, chaired by a senior social worker, to determine if abuse has occurred, its nature, whether the child's name should be placed on the Child Protection Register, and what must be done to protect the child from further harm. Where there is doubt or the parents dispute the decisions being made, the Courts are the ultimate arbiter.

The obligation to network with these other agencies means that, unlike most other areas of clinical practice, doctors dealing with possible child protection issues are not 'in charge' of the case—but the fact that legal responsibility rests with the chair of the child protection conference, and, ultimately with the judiciary, means that doctors do not have to carry the whole burden themselves. This is just as well, because often the information available is incomplete and sometimes there is a high degree of uncertainty. Doctors sometimes come under pressure from the conference chair, the police or lawyers, to be decisive but if they go beyond what the evidence justifies, they may be doing serious harm to the child and family as well as putting their own professional reputation at risk.

Recent controversies

To those not intimately connected with child protection research, recent high profile controversies must seem bewildering. Reporting in much of the media has been inaccurate, sometimes scandalously so. The issue that has attracted the most attention is the relationship between MSBP or FII and sudden infant death syndrome (SIDS). Other areas of controversy include the diagnosis of child sexual abuse, the problem of 'shaken baby syndrome' and the extent to which abnormally fragile bones might account for unexplained fractures. This review will focus on the first of these as it is the topic which has had the biggest impact on the profession and the public.

MSBP, FII and SIDS

Almost 30 years ago three papers reported cases in which parents presented their children to doctors with signs and symptoms which they had in fact fabricated themselves.³ Meadow is (incorrectly) credited with the first use of the term and concept of 'Munchausen syndrome by proxy'. The world literature now includes some hundreds of cases, with a wide range of manifestations, including the

deliberate poisoning of children by salt or medications, contamination of body fluids to mimic serious problems such as haematuria, and the fabrication of a history suggestive of epilepsy. Initially it was thought that the perpetrator, who is usually the mother, could be shown to have a typical personality profile, but it is now clear that this was an over-simplification. As the spectrum is so broad and the psychopathology of the perpetrator is so poorly understood, the focus is now on the presenting features in the child, hence the preferred term is now fabricated and induced illness—FII.⁴

Over the past 40 years there has also been much interest in why some previously well infants died suddenly (SUDI—sudden unexpected death in infancy). Early theories about recurrent apnoeic attacks as a cause of SUDI did not stand up to critical examination and the term 'sudden infant death syndrome' was coined to take account of the negative post-mortem findings and the lack of any satisfactory explanation after thorough investigation. In the course of studying babies with a history of apnoea, Southall *et al.* realized that some such cases were due to deliberate obstruction of the airway by an adult. They demonstrated this to a disbelieving profession by means of physiological monitoring combined with covert video surveillance.⁵ Their work had a hostile reception from some colleagues who commented on the damage to the doctor–patient relationship, forgetting that to a paediatrician the child is the patient to whom one owes a duty of care—and, in these circumstances, that duty includes protecting a helpless patient from assault. Aggressive public campaigning by parent groups⁶ and the media against doctors who diagnose FII have had a devastating effect on clinical practice, research and morale and, by inference, on the protection of children.⁷

There is no doubt that deliberate suffocation happens, although we still understand very little about the reasons for such actions. The question arose as to whether deliberate suffocation of infants was a form of MSBP. This question is now less relevant since the term was abandoned in favour of FII, but it does seem likely that the perpetrators' psychopathology in the cases described by Meadow and others may be different from that seen in deliberate airway obstruction and suffocation.

More important is the question of how many cases thought to be SIDS might in fact be non-accidental deaths due to deliberate suffocation. The question is all but impossible to answer. There are no reliable markers of SIDS or of deliberate suffocation at autopsy and even the most comprehensive investigation may be unhelpful. An even more difficult issue is the extent to which one ought to suspect non-accidental death when a family suffers the tragedy of two unexplained sudden deaths. The Confidential Enquiry into Stillbirths and Deaths in Infancy study showed that the risk of SIDS is strongly related to smoking, low

income and maternal age and parity. Families with all the risk factors experienced a 40-fold difference in SIDS rates compared to those at lowest risk (1:214 versus 1:8543). The authors of the CESDI report squared the latter figure to calculate the odds against two SIDS cases occurring in any given low-risk family. This produced the statistic of 1:73 million which Meadow quoted in Court and for this, to the dismay of expert witnesses in all walks of life, he was struck off the medical register. It is now recognized that the approach would be legitimate only if SIDS were a truly random event. The occurrence of one death suggests that subsequent infants in that family may be exposed to similar genetic or environmental hazards and, at least in theory, have an increased risk of unexpected death.

There have been several attempts to assess that risk empirically. The largest and most recent study, by Carpenter *et al.*⁸ followed up 6373 subsequent infants of families who had lost a baby through sudden unexpected death, believed to have been due to SIDS. The authors concluded that the risk of a second death is indeed increased for a family who have had one death diagnosed as SIDS. In some cases, the circumstances raised doubts as to whether the death was natural but the authors allocated these deaths to the SIDS category. This approach was severely criticized in subsequent correspondence and it was suggested that the true number of unnatural deaths may be significantly higher.⁹ In the 18 cases fully investigated and thought to be true cases of a second SIDS, the authors stated that all the families had a 'high frequency of SIDS risk factors' and in this series of repeat deaths the authors did not describe any unequivocal example of two SIDS in one low-risk family.

Although these issues are still controversial, there is widespread agreement on two points. First, when an infant dies unexpectedly it is in everyone's interests to ensure that a thorough multi-agency investigation is done at the time. This includes not only a comprehensive post-mortem examination that includes a search for genetic disorders, but also detailed interviews with the parents as soon as possible after the event and a visit to the scene of death.¹⁰ Inadequate initial assessment may lead subsequently to a request for second or medico legal opinions but, although review of all the data may be worthwhile, interviewing parents weeks or months after the event is thought by most paediatricians to be unhelpful and may simply confuse matters further. Second, criminal proceedings and convictions that rely heavily on probability statistics about the risk of more than one unexplained death in a family are unjustified and hazardous.

Restoring confidence in child protection work

In order to ensure that the next generation of paediatricians, and other doctors (psychiatrists, pathologists,

ophthalmologists, orthopaedic surgeons, radiologists) involved in child protection can practise effectively and without risk to their professional careers, three main steps are needed—changes in the regulatory system, a stronger evidence base and better training and continuing education.

The unequivocal guidance from the judiciary is that where child protection is concerned a paediatrician owes a duty of care only to the child, not to the parents, while the Children Act makes it clear that the child's interests are paramount.^{11,12} With regret, it must be recorded on behalf of many UK doctors that they currently have no confidence in the competence of the regulatory authorities to apply this guidance when making judgments about the expertise or professional behaviour of those working in child protection, nor do they believe that the authorities are able to withstand public, political and media pressures in high profile cases. Changes in the way complaints are managed are urgently needed.

The evidence base on many aspects of child protection is still weak. It is a bitter irony that among the doctors who have been called before the General Medical Council are several who have contributed so much to our knowledge of child abuse. Indeed, as a result of their work the diagnosis of FII is often more robust than in many other aspects of child abuse. However, recent systematic reviews^{13–15} have revealed that there is still surprisingly little reliable evidence on many forensic questions, for example the ageing or patterns of bruises, the significance of human bite marks, the best-buy approach to autopsy after unexplained death or the physical signs of sexual abuse. The issue of a genetic pre-disposition to sudden death and to fractures is also attracting interest. Clearly we must ensure that more and better research is undertaken and that as clinicians we honestly acknowledge uncertainty.

The Royal College of Paediatrics and Child Health has initiated a series of measures to improve training in child protection. Some have misinterpreted this as an admission of past failings but the main motives are to restore confidence in child protection work and to ensure that all paediatricians can keep up with the emerging evidence and debates in the field.

The future

Our hope is that protecting children will once again be seen as a core part of paediatric practice and that health professionals can continue clinical work and research with skill, compassion and humility, recognizing the difficulties, but aware of their duty to protect children from cruelty, abuse and neglect. Our aim is that they will no longer need to be pre-occupied with the risk of having their career abruptly interrupted or terminated by inappropriate management of complaints about their work.

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